PRINTED: 10/14/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES  OMB NO. 0938-039							B NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPL	ETED	
15G040			B. WIN			09/23/2	011
NAME OF A	DOLUBER OR GURRI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		300 W 5	53RD AVE		
ARC BR	DGES, INC		GARY, IN46410				
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUNDED FOR THE APP) TAG (EACH CORRECTIVE ACTION SHOUNDED FOR THE APP) TAG (EACH CORRECTIVE ACTION SHOUNDED FOR THE AC		ΙΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
W0000							
			l W	0000			
	This visit was for the	ne investigation of complaint					
	#IN00096116.	in investigation of companie					
	Complaint #IN0009	96116: SUBSTANTIATED,					
	Federal and State d	eficiencies related to the					
	allegation are cited	at W125 and W137.					
	Unrelated deficiency cited.						
	Dates of survey: September 21, 22, and 23, 2011.						
	Facility number: 0	00507					
	Provider number: 1						
	AIM number: 1002						
	7 Mivi namber: 1002	33420					
	Surveyor: Susan E III/QMRP	akright, Medical Surveyor					
	findings in accorda	ciencies also reflect state nce with 460 IAC 9. mpleted 10/4/11 by Ruth cal Surveyor III.					
W0125	clients. Therefore encourage indivic rights as clients o of the United Stat	ensure the rights of all e, the facility must allow and lual clients to exercise their f the facility, and as citizens es, including the right to file he right to due process.	W	0125	The lock was removed and		09/23/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on observation and interview, for 5 of 5

clients (clients A, B, C, D, and E) who resided in

supply, toilet paper, paper towels, and hand soap.

the group home, the facility failed to allow and

encourage access to the facility's locked food

TITLE

000597

reviews of rights are done

maintenance verification was

future compliance, personal

grooming/hygiene items will be

stored in an unlocked area and

presented to surveyor. To ensure

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY  COMPLETED	
		IDENTIFICATION NUMBER:	A. BUI	LDING	00	09/23/201		
		15G040	B. WIN	G		09/23/20	11	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1	53RD AVE			
ARC BR	IDGES, INC			GARY, I	IN46410			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					annually with HRC.			
	Findings include:							
	On 9/21/11 from 4:	45pm until 5:40pm.						
		erview were completed at client						
	1	group home. During the						
		the hallway closet was kept						
		ient C exited the hallway						
		d to DCS (Direct Care Staff) #1						
	"I need toilet paper.	" DCS #1 went to the hallway						
	closet, removed a k	ey from her pocket, unlocked						
	1	loor, and retrieved a roll of						
		1 locked the hallway closet						
		oll of toilet paper to client C.						
		oll of toilet paper to client A						
	1	e bathroom door. At 5pm,						
	1	he hallway closet door and						
	1	closet was "kept locked." DCS						
	1	f had the keys" to the locked						
		DCS #1 stated the facility						
	1 -	ilet paper, paper towels, and						
		he locked hallway closet. At						
	1 ^	QMRP (Qualified Mental						
	Retardation Professional), and DCS #2 indicated they did not know why the hallway closet was kept							
	1 -	-						
	locked and the clients did not have a key. From 4:45pm until 5:40pm, three of three bathrooms did not have paper towels or hand soap for clients A, B, C, D, and E.  The QMRP was interviewed on 9/22/11 at 11:50am. The QMRP indicated there was no identified need for the hallway closet to be locked containing the food supply, hand soap, toilet paper, and paper towels. The QMRP indicated clients A, B, C, D, and E did not have a key for the locked closet.							
	This federal tag rela	ates to complaint						
	#IN00096116.	to companie						
	•							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LVL411

Facility ID:

000597

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		15G040	A. BUILDING 00		COMPLETED 09/23/2011	
15G040			B. WING		09/23/2011	
NAME OF P	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE		
ARC BRI	DGES, INC		l l	53RD AVE IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	9-3-2(a)					
W0137	The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.		W0127	The lock was removed 9/22/	11 00/22/2011	
Based on observation and interview, for 5 of 5 clients (clients A, B, C, D, and E) who resided in the group home, the facility failed to allow and encourage clients A, B, C, D, and E access to their personal hygiene boxes locked inside the hallway closet.		W0137	and maintenance verification presented to surveyor. To ensure future compliance personal grooming/hygiene i will be stored in an unlocked and reviews of rights are dor annually with HRC.	n was s, items		
	Findings include:					
	A, B, C, D, and E's gobservation period, locked. At 5pm, clic bathroom and stated "I need toilet paper.' closet, removed a ket the hallway closet de and E's personal hygmiddle shelf. DCS door and gave the roat 5pm, DCS #1 unland stated the hallway Closet de and stated the hallway Closet facility kept client A "hygiene boxes lock QMRP (Qualified M Professional), and D	rview were completed at client group home. During the the hallway closet was kept ent C exited the hallway to DCS (Direct Care Staff) #1 'DCS #1 went to the hallway by from her pocket, unlocked oor, and clients A, B, C, D, giene boxes were visible on the #1 locked the hallway closet oll of toilet paper to client C. locked the hallway closet door ay closet was "kept locked." It is staff had the keys" to the et door. DCS #1 stated the L, B, C, D, and E's personal ed." At 5pm, DCS #1, the lental Retardation of CS #2 indicated they did not ay closet was kept locked and				

Facility ID:

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  OO			(X3) DATE SURVEY COMPLETED		
		15G040	A. BUILDING B. WING		<del></del>	09/23/2011		
NAME OF PROVIDER OR SUPPLIER  ARC BRIDGES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE  300 W 53RD AVE  GARY, IN46410					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROGRAMMENT AND GODDENSTON		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  ORGENTAL EXCHANGE IN THE ATTROCKMENT OF				DATE			
	The QMRP was interviewed on 9/22/11 at 11:50am. The QMRP indicated there was no identified need for client A, B, C, D, and E's personal hygiene boxes to be locked. The QMRP indicated clients A, B, C, D, and E did not have a key for the locked closet.  On 9/22/11 at 12:30pm, client B, C, D, and E's records were reviewed and did not indicate the need for locked personal hygiene boxes.  On 9/22/11 at 12:15pm, client A's record was reviewed and did not indicate the need for her personal hygiene box to be locked.  This federal tag relates to complaint #IN00096116.  9-3-2(a)							
W0436	repair, and teach of informed choices are eyeglasses, hearing communications and evices identified as needed by the desired as needed by the desired as needed by the desired interview, for 1 of 2 wore prescription eyencourage and teach prescribed eye glass.  Findings include:  On 9/21/11 from 4:4 did not wear her prescription eyencourage and teach prescribed eyencourage eyencour	ids, braces, and other by the interdisciplinary team client.  n, record review, and sample clients (client A) who re glasses, the facility failed to a client A to wear her	W0436	5	DSPs have been retrained to prompt client to wear glasses To ensure future compliance, client glasses placement is no being documented on the MA	s. , the ow	10/23/2011	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G040		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	(X3) DATE SURVEY COMPLETED 09/23/2011			
NAME OF PROVIDER OR SUPPLIER  ARC BRIDGES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE  300 W 53RD AVE  GARY, IN46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	butcher knife, cut ar and no eye glasses vencouraged.  The QMRP (Qualiff Professional) was in 9:25am. The QMR prescription eye glaclient A should have to wear her prescrip the tomato and onio On 9/22/11 at 12:15 reviewed. Client A'Support Plan) indicaglasses. Client A's 4	ed Mental Retardation terviewed on 9/23/11 at P indicated client A wore sees. The QMRP indicated to been taught and encouraged tion eye glasses when she cut n with a butcher knife.  pm, client A's record was s 2/17/11 ISP (Individual ated she wore prescription eye 4/26/11 vision exam indicated s unchanged and the client		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE HE APPROPRIATE			